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MEDICAID MEMO

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Summary of New Federal Targeted Case Management Final Regulations – Effective March 3, 2008

The purpose of the Memorandum is to assist you in familiarizing yourself with the new Federal Targeted Case Management Final Regulations which recently became effective. On December 4, 2007, the Centers for Medicare and Medicaid Services (CMS) issued an "Interim Final Rule with Comment Period" implementing provisions of the 2006 Deficit Reduction Act and making other changes to reimbursement for targeted case management services. The rule was effective March 3, 2008.

The rule defines allowable case management services and requires reimbursement to be in 15 minute units. The Interim Final Rule applies to the following case management services.

Service Description (Procedure Code)	Current Billing Unit
Mental Health Case Management (H0023)	Month
Mental Retardation Case Management (T1017 modifier U3)	Month
Developmentally Disabled Case Management (T2023)	Month
BabyCare Case Management (G9002)	Day
Treatment Foster Care Case Management (T1016)	Month
AIDS Case Management (T1016)	Hour
Substance Abuse Case Management (H0006)	15 minutes
Elderly Case Management (T1016)	Hour

CMS has indicated that States are potentially at audit risk if not in compliance with the new rule, but have provided little guidance to states

and providers on how to implement the rule. While the Department of Medical Assistance Services (DMAS) is not prepared

to implement a 15 minute billing unit immediately, DMAS is prepared to retroactively settle reimbursement if necessary. DMAS may be required to prove that claims submitted for service dates after March 3, 2008 are consistent with the 15 minute billing unit required in the regulation. In order to do so, providers need to begin documenting the total allowable case management service time as soon as practicable while continuing to bill in the current manner. The only exception is Substance Abuse Case Management, which is already billable in 15 minute units.

DMAS advises providers to document total billable minutes for allowable case management services furnished to Medicaid recipients on a monthly basis. Allowable case management services are described in the attached summary.

Many providers already have record systems that document the information necessary to support the billing of services. You may use these systems to record billable time. Whatever system is used, however, the documentation should include the following information:

Medicaid Recipient Name
and ID Service Date

Total Billable
Minutes Service
Provider Name

Short Description of Activity (for example, assessment,
development of plan of care, making an appointment, etc.)

In addition, providers must have documentation to support all of the time billed. Documentation must include all of the time billed in minutes and can be recorded on logs, automated billing tickets, or other means of capturing information. Progress notes must summarize activities included in the documentation. The frequency of the progress notes remains the same as what is currently required.

DMAS recommends that providers document case management service time in the event there is an audit. At this time providers do not need to take any further action. DMAS will provide additional guidance and instructions as soon as more information is available.

Included with this memo is guidance regarding allowed activities for case management services.

DMAS Summary of Allowable Case Management Activities Based on the CMS Interim Final Rule on Targeted Case Management (Published in Federal Register December 4, 2007)

Case management assists individuals to gain access to needed medical, social, educational, and other services, (such as housing and transportation).

The following services and activities are allowed:

- Assessment and planning services, to include history taking, gathering information from other sources, developing and writing an Individual Services Plan - ISP (does not include performing medical and psychiatric assessment, but does include referral and time spent in preparing the referral for an assessment). Periodic re-assessments are included.

- Linking (referring) the individual to services and supports specified in the Service Plan. This includes making appointments. Accompanying the individual to appointments or transporting them is not covered. Providers may want to record the time spent transporting individuals in the event that CMS provides guidance that this is allowed. At this time, it appears that CMS does not allow any type of transportation.

- Coordinating services and planning treatment with other agencies and providers.

  - Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

  - Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

  - Monitoring and follow up -service delivery as needed through contacts with service providers as well as periodic site visits and home visits.

  - Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific recipients. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are

not case management activities. Allowed educational activities would include discussion of why activities listed in the service plan are beneficial to the individual.

Limits imposed by the Interim Final Rule

- Only one case management agency per individual is allowed. CMS is allowing a phase-in of this requirement and it is not effective immediately.
  - Payment increments are no more than 15 minutes.
  - No direct services are allowed within case management. Please see the clarification under the Education and counseling bullet above. CMS considers a direct service to be therapy, examinations, or other treatment.
  - Services must be provided to or on behalf of the individual and are not group based interventions.
  - Case Management must be provided at the option of the client, it cannot be required as a condition of receiving another service.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30

a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free

long distance) Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers.

Covered topics will include upcoming changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr- enewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memoranda, Medicaid Provider Manuals, or any other official correspondence from DMAS.